HEALTH HISTORY FORM

NAME_____ ☐SINGLE ☐MARRIED ☐PARTNERED ☐WIDOWED ☐DIVORCED
AGE_____ BIRTHDATE_____ S.S. NO._____ EMAIL ADDRESS_____
RESIDENCE ADDRESS_____ HOME PHONE_____
CELL PHONE_____
EMPLOYED BY_____ BUS. PHONE_____
PRESENT POSITION_____
NAME OF SPOUSE_____ SPOUSE EMPLOYER_____
REFERRED BY_____
PERSON RESPONSIBLE FOR THIS ACCOUNT_____
DENTAL INSURANCE PLAN (IF ANY)_____
INSUR. CO. GROUP NO. EMPLOYER NAME INSURED'S NAME INSURED SS#

IT IS IMPORTANT THAT I KNOW ABOUT YOUR DENTAL AND MEDICAL HISTORY, MANY THINGS HAVE A DIRECT BEARING ON YOUR DENTAL TREATMENT, INFORMATION YOU PROVIDE IS STRICTLY CONFIDENTIAL.

YOUR MEDICAL HISTORY

PHYSICIAN'S NAME_____ PHONE NO._____
DATE OF LAST VISIT_____ FOR WHAT PURPOSE?_____
HAVE YOU EVER HAD A SERIOUS ILLNESS OR BEEN HOSPITALIZED? ☐ YES ☐ NO
IF SO, EXPLAIN_____
CURRENT BLOOD PRESSURE_____/_____
DO YOU PREMEDICATE WITH AN ANTIBIOTIC PRIOR TO DENTAL WORK? ☐ YES ☐ NO
INDICATE WITH A CHECK MARK ANY OF THE FOLLOWING WHICH APPLY TO YOUR PAST OR PRESENT HEALTH

_____ALLERGIES TO LOCAL ANESTHETICS
_____ALLERGIES TO MEDICINE OR DRUGS
_____
_____OTHER ALLERGIES_____
_____HEART ATTACK (M.I.)
_____HEART CONDITION _____
_____HEART MURMUR
_____HIGH BLOOD PRESSURE
_____LOW BLOOD PRESSURE
_____CARDIAC PACEMAKER
_____ARTIFICIAL HEART VALVE
_____SHORTNESS OF BREATH
_____BRUISE EASILY
_____SWELLING OF ANKLE
_____STROKE
_____RHEUMATIC FEVER
_____ANEMIA
_____BLEED EXCESSIVELY
_____BLOOD THINNER (COUMADIN, ASPIRIN, PLAVIX, TICLID)
_____FAINTING OR DIZZINESS
_____MIGRAINE HEADACHES
_____ARTIFICIAL JOINT (HIP, KNEE, etc.)

_____EPILEPSY, SEIZURES
_____BLOOD TRANSFUSIONS
_____HEPATITIS A B C (CIRCLE)
_____CANCER
_____CHEMOTHERAPY
_____RADIATION THERAPY
_____TRANSPLANTS
_____ARTHRITIS, RHEUMATISM
_____STEROIDS (CORTISONE)
_____BISPHOSPHONATE (FOSAMAX, ACTONEL, BONIVA)
_____DIABETES
_____GLAUCOMA
_____ASTHMA
_____LUNG DISEASE (i.e EMPHYSEMA)
_____TUBERCULOSIS
_____STOMACH ULCERS
_____PSYCHIATRIC/PSYCHOLOGICAL CARE
_____SINUS PROBLEMS
_____COLD SORES
_____HERPES
_____VENEREAL DISEASE
_____AIDS/HIV POSITIVE

IF FEMALE, ARE YOU CURRENTLY PREGNANT? ☐ YES ☐ NO
DO YOU HAVE ANY DISEASE, CONDITION, OR PROBLEMS NOT LISTED ABOVE?_____
MEDICATIONS PRESENTLY BEING TAKEN: _____
_____

(OVER)

YOUR DENTAL HISTORY

1. WHAT IS THE REASON FOR YOUR VISIT? _____
2. DATE OF LAST DENTAL VISIT?_____ WHAT WAS DONE AT THAT VISIT? _____
3. DATE OF LAST CLEANING? _____ HOW OFTEN DO YOU HAVE CLEANINGS?_____

YES	NO	
____	____	ARE YOU HAVING ANY DISCOMFORT AT THIS TIME? WHERE?_____
____	____	DO YOU HAVE ANY SENSITIVE TEETH? (HOT, COLD, SWEETS)? WHERE?_____
____	____	DO YOU HAVE DISCOMFORT WHEN BITING OR CHEWING? WHERE? _____
____	____	DO YOU HAVE SWELLING OR A LUMP IN YOUR MOUTH? WHERE? _____
____	____	DO YOU HAVE ANY UNPLEASANT TASTES IN YOUR MOUTH?
____	____	DO YOU HAVE ANY CONCERNS ABOUT HAVING BAD BREATH (HALITOSIS)?
____	____	DOES FOOD WEDGE BETWEEN YOUR TEETH? WHERE? _____
____	____	ARE YOU SATISFIED WITH THE APPEARANCE OF YOUR TEETH? (COLOR, SHAPE, OVERALL SMILE)
		_____
____	____	HAVE YOU EVER HAD PERIODONTAL (GUM) TREATMENT? BY WHOM? _____
____	____	HAVE YOU EVER HAD ORTHODONTIC (BRACES) TREATMENT? BY WHOM? _____
____	____	HAVE YOU EVER HAD ENDODONTIC (ROOT CANAL) TREATMENT? BY WHOM?_____
____	____	HAVE YOU EVER HAD ORAL SURGERY OR IMPLANTS PLACED? BY WHOM? _____
____	____	HAVE YOU HAD A FULL MOUTH SERIES OF X-RAYS (18) TAKEN WITHIN THE PAST YEAR?
____	____	DO YOU HAVE PAIN IN OR NEAR YOUR EARS, POPPING, CLICKING NOISES WHEN CHEWING?
____	____	IS THERE PAIN ON OPENING WIDE OR MOVING YOUR JAW FROM LEFT TO RIGHT?
____	____	ARE YOU AWARE IF YOU GRIND OR CLENCH YOUR TEETH?
____	____	HAVE YOU EVER HAD AN INJURY OR TRAUMA TO YOUR FACE OR JAW?
____	____	DO YOU SMOKE OR CHEW TOBACCO?
____	____	DO YOU USE DENTAL FLOSS? HOW OFTEN? _____
		WHAT TYPE OF TOOTHBRUSH DO YOU USE? ☐ SOFT BRISTLE ☐ ELECTRIC

NOTICE OF PRIVACY PRACTICES:

I HAVE BEEN INFORMED OF AND BEEN GIVEN THE RIGHT TO REVIEW AND SECURE A COPY OF YOUR NOTICE OF PRIVACY PRACTICES.

VISUAL IMAGES: I GIVE DR. SUPOWITZ PERMISSION FOR VISUAL IMAGES OF MY SMILE (TEETH AND LIPS ONLY, NOT FULL FACE) OBTAINED IN CONNECTION WITH MY DENTAL EXAMINATION AND/OR TREATMENT TO BE UTILIZED FOR EDUCATIONAL PURPOSES PRIMARILY IN HIS OFFICE, BUT MAY BE UTILIZED FOR EDUCATIONAL PRESENTATIONS TO DENTISTS, DENTAL STUDENTS, PATIENTS AND ON HIS COPYRIGHTED WEBSITE. THE SMILE IMAGES WILL NOT HAVE MY NAME ASSOCIATED WITH THEM.

APPOINTMENTS: ONCE AN APPOINTMENT HAS BEEN MADE, PLEASE REMEMBER THIS TIME HAS BEEN RESERVED FOR YOUR EXCLUSIVE USE. A CHARGE MAY BE MADE FOR CANCELLED APPOINTMENT WITHOUT PRIOR NOTIFICATION OF AT LEAST 24 HOURS.

INSURANCE: AS A SERVICE TO YOU, OUR OFFICE WILL SUBMIT TO YOUR INSURANCE COMPANY, FEES FOR SERVICES RENDERED. THE PATIENT IS UTLIMATELY RESPONSIBLE FOR THAT PORTION OF THE FEE WHICH IS NOT PAID BY THE INSURANCE COMPANY.

I CERTIFY THAT I HAVE READ AND UNDERSTAND BOTH SIDES OF THIS FORM. I ACKNOWLEDGE THAT MY QUESTIONS, IF ANY, ABOUT INQUIRIES SET FORTH ABOVE HAVE BEEN ANSWERED TO MY SATISFACTION. I WILL NOT HOLD MY DENTIST, OR ANY OTHER MEMBER OF HIS STAFF, RESPONSIBLE FOR ANY ERRORS OR OMISSIONS THAT I MAY HAVE MADE IN THE COMPLETION OF THIS FORM.

INSURANCE ASSIGNMENT AND RELEASE:

I AUTHORIZE DR. SUPOWITZ AND/OR ANY PROVIDERS OF SERVICES IN THIS OFFICE TO RELEASE THE INFORMATION REQUIRED TO SECURE THE PAYMENT OF BENEFITS. I AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS. I AUTHORIZE PAYMENT DIRECTLY TO DR. SUPOWITZ OF INSURANCE BENEFITS OTHERWISE PAYABLE TO ME FOR SERVICES RENDERED.

SIGNATURE OF PATIENT _____ DATE_____

SIGNATURE OF RESPONSIBLE PARTY_____ DATE_____

MARTIN L. SUPOWITZ, DMD, MSD PITTSBURGH, PA
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